

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Tadeo                                       | CHAPTER 100.1                               |
| Address:<br>17-566 S. Ipuaiwaha Street, Keeaau, Hawaii 96749 | Inspection Date: February 25, 2020 – Annual |

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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HAWAIIAN STATE  
JAN 27 2020  
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8514 11 AM 02.

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| RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion<br>Date                         |
|---|---|--|
| <input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u><br>(b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.<br><u>FINDINGS</u><br>Primary care giver (PCG) with a history of past positive tuberculosis (TB) skin test, no current TB attestation. | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><u><b>DID YOU CORRECT THE DEFICIENCY?</b></u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU<br/>CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">OBTAINED TB<br/>I WILL OBTAIN A TB ATTESTATION ON<br/>3-27-20.</p> | <p style="text-align: center;">3-27-20</p> |

| RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                            |
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| <input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements.<br>(b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.<br><br><u>FINDINGS</u><br>Primary care giver (PCG) with a history of past positive tuberculosis (TB) skin test, no current TB attestation. | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>TO ENSURE THAT THIS DOES NOT HAPPEN AGAIN, ON MY NEXT ANNUAL PE AND TB CLEARANCE I WILL HAVE MY TB ATTESTATION RECALLY AVAILABLE FOR MY PHYSICIAN TO CONDUCT IMMEDIATELY. I WILL ALSO RE-CHECK ALL PAPERWORKS ARE PROPERLY FILED BUT PRIOR TO LEAVING THE OFFICE.</p> | <p style="text-align: center;">3-21-20</p> |

STATE LICENSING  
 HEALTH CARE  
 DIVISION  
 STATE OF HAWAII

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| RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date |
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| <input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(1)<br>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br><br>Documentation of primary care giver's assessment of resident upon admission;<br><br><u>FINDINGS</u><br>Resident #1, no admission assessment completed upon re-admission of March 25, 2019. | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency<br/>after-the-fact is not<br/>practical/appropriate. For<br/>this deficiency, only a future<br/>plan is required.</b></p> <p style="text-align: center;"> <small>             MISSISSIPPI<br/>             DEPARTMENT OF<br/>             HEALTH SERVICES<br/>             DIVISION OF<br/>             LICENSING<br/>             COMMUNITY CARE<br/>             DIVISION<br/>             MAR 11 11 59 AM '19           </small> </p> |                 |

| RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                           |
|--|--|---|
| <input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(1)<br>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br><br>Documentation of primary care giver's assessment of resident upon admission;<br><br><u>FINDINGS</u><br>Resident #1, no admission assessment completed upon re-admission of March 25, 2019. | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>TO ENSURE THAT THIS DOES NOT HAPPEN AGAIN, I WILL IMMEDIATELY COMPLETE MY ADMISSION ASSESSMENT UPON RE-ADMISSION FOR ALL CURRENT AND FUTURE RESIDENTS. I WILL ALSO DOUBLE CHECK MY FIRST CHECKLIST TO CONFIRM THAT I COVERED ALL NECESSARY DOCUMENTS FOR RE-ADMISSION.</p> <p style="text-align: right;">             LICENSING<br/>             DIVISION<br/>             STATE OF HAWAII<br/>             65:14 11 MAR 02.           </p> | <p style="text-align: right;">0.25.20</p> |

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| RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date |
|---|---|-----------------|
| <input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(4)<br>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br><br>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;<br><br><u>FINDINGS</u><br>Resident #1, no physical examination prior to re-admission of March 25, 2019. | <div data-bbox="1312 1268 1344 1386">PART 1</div> <div data-bbox="607 974 935 1684"> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> </div> <div data-bbox="373 1394 451 1596"> STATE OF HAWAII<br/> COMMUNITY DEVELOPMENT<br/> STATE LICENSING </div> <div data-bbox="276 1344 311 1625"> MAR 11 11 59 AM '02 </div> <div data-bbox="159 1369 198 1591"> RECEIVED </div> |                 |

| RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                            |
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| <input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (a)(4)<br>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br><br>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;<br><br><u>FINDINGS</u><br>Resident #1, no physical examination prior to re-admission of March 25, 2019. | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>TO AVOID THAT THIS DOES NOT HAPPEN AGAIN, I WILL IMMEDIATELY OBTAIN A CURRENT PHYSICAL EVALUATION CONDUCTED BY A PHYSICIAN BEFORE RE-ADMITTING ALL CURRENT AND FUTURE RESIDENTS. I WILL DOUBLE CHECK ALL CERTIFIED TO CONFIRM THAT ALL RECORDS ARE COMPLETED FOR RE-ADMISSION.</p> <div style="text-align: right;">             2.25.20<br/>             RECEIVED<br/>             65:1 D 11 MAR 02.<br/>             STATE OF HAWAII<br/>             COMMUNITY<br/>             STATE LICENSING           </div> | <p style="text-align: center;">2.25.20</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(6)<br/> The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:<br/><br/> Physician or APRN signed orders for diet, medications, and treatments;</p> <p><b><u>FINDINGS</u></b><br/> Resident #1, no medication orders upon re-admission of March 25, 2019. Medication orders obtained on April 1, 2019.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency<br/>after-the-fact is not<br/>practical/appropriate. For<br/>this deficiency, only a future<br/>plan is required.</b></p> <p style="text-align: center;">STATE LICENSING<br/>DOH-HICA<br/>STATE OF HAWAII</p> <p style="text-align: center;">65:14 11 MAR 02.</p> |                 |

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| <input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (b)(3)<br>During residence, records shall include:<br><br>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;<br><br><b>FINDINGS</b><br>Resident #1, no progress note documenting emergency room visit of November 29, 2019. | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency<br/>after-the-fact is not<br/>practical/appropriate. For<br/>this deficiency, only a future<br/>plan is required.</b></p> <p style="text-align: center;">STATE LICENSING<br/>COMMUNITY<br/>STATE OF HAWAII</p> <p style="text-align: center;">65:14 11 MAR 02.</p> <p style="text-align: center;">RECEIVED</p> |                 |

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CHANGING TIMES  
 YOUR-OWN  
 IN WITH ALL THIS

69:18 11 MAR 02.

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| RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date |
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| <input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (c)<br>Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.<br><br><b><u>FINDINGS</u></b><br>Resident #1, no incident report for emergency room visit and hospitalization of November 29, 2019.<br><b><u>This is a repeat deficiency from your 2019 annual inspection.</u></b> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency<br/>after-the-fact is not<br/>practical/appropriate. For<br/>this deficiency, only a future<br/>plan is required.</b></p> <div style="text-align: center;">  <p>6514 11 W 02.</p> </div> |                 |

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|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 Physical environment. (h)(3)<br/>           The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><u>FINDINGS</u><br/>           Opened bag of rice stored on kitchen floor.</p> | <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>PART 1</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I REMOVED THE OPENED BAG OF RICE OFF THE FLOOR, PLACED IT IN A CLOSED CONTAINER AND STORED IT IN THE PANTRY</p> | <p>2.25.20</p>  |

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Licensee's/Administrator's Signature:



Print Name:

Riana Lopez

Date:

3.9.20

STATE OF ILLINOIS  
DEPARTMENT OF  
STATE LICENSING

20 MAR 11 P1:59

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